SOUTHWEST REGION CONFERENCE OF SEVENTH-DAY ADVENTIST

CONSENT TO TREATMENT

Student's Name ____

Age ______ Birthdate: ___ __________ Social Security Number ____________________
MM/DD/YY

Address ____

Parent's/Guardian's Name ____

Father/Guardian ____
Business Phone Social Security Number

Mother/Guardian ____
Business Phone Social Security Number

Describe allergies: ____

Date of last tetanus shot: ______________________

Provide your local family medical information in case your son or daughter becomes ill or has an accident at school and you cannot be reached:

1. Family Physician ______________________ Office Telephone ______________

   Address ____

2. Family Physician ______________________ Office Telephone ______________

   Address ____

Hospital Preference ____

Provide the name of two relatives or friends who have consented to assume responsibility of your son or daughter in case of illness or accident until you can be reached. In case of any changes in the named persons, notify the school in writing.

1. Name ______________________________ Telephone ______________

   Address ____

2. Name ______________________________ Telephone ______________

   Address ____

If emergency service involving medical action or treatment is required and neither the parent nor family physician can be reached for consent, the parent hereby consents to the rendering of such emergency medical service for the above named student as shall be necessary in the medical opinion of the doctor rendering the service. The authorization is give pursuant to the local state Civil Code.

Parent's/Guardian's Signature __________________________ Date ______________